Wholeness Center

Adult Registration

Patient's Name:_____ Birth Date:_____ Age:_____
Street Address: _____
City: _____State: _____Zip: _____Sex: M/F
Contact Email*: (*required to receive access to your Personal Health Record Portal)

_____
Emergency Contact: _____Emergency Contact Phone: _____
Emergency Contact Relation to Patient: _____
How did you hear about us? _____

Context of Care Review

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires.

What concerns bring you to our clinic? _____

_____
Have you been treated for this problem before? _____
Was there any event or action that you or others think that might have contributed to your symptoms (be as detailed as possible)? _____

_____

_____
Are you currently receiving healthcare? Yes/No
If yes, where and from whom? _____
List any accidents, illnesses, injuries, hospitalizations/surgeries or imaging (X-ray, CAT scan, MRI etc):

_____

_____
Are you hypersensitive or allergic to:
Drugs/medications?_____
Foods?_____
Environmental or chemicals? _____
What long term expectations do you have from working with our clinic?

_____

_____

Current Medications and Supplements

List all medications (from drugstore or prescription) you are taking and dosages:

_____ _____

_____ _____

_____ _____

List all supplements you are taking and dosages:

_____ _____

_____ _____

_____ _____

Current Lifestyle

Highest Education Level:_____ Occupational status: _____
Relationship status: _____
Name of partner: _____Years together: _____Partner's age: _____
Partner's occupation: _____Partner's education level: _____
Partner's Present Health: _____
Total number of children: _____
Prior marriage(s)? Yes/No If yes, date and length of marriage(s):_____
Partner's prior marriage(s) Yes/No If yes, date and length of marriage(s):_____
What are your top three stressors? Please list and briefly explain:
1. _____
2. _____
3. _____
What are your personal strengths: _____

_____
Have you ever had legal issues? Yes/No If yes, please explain:_____

_____

_____
Have alcohol and/or drugs caused you problems? Yes/No If yes, please explain:_____

_____

_____
Who in your immediate family and extended family has had psychiatric/psychological problems and/or addiction issues? _____

_____
List what you eat during a typical day and at what time:
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____
Drinks:_____
Do you use caffeine products (soda, coffee, tea, etc,)? Yes/No How Much?_____
What foods/drinks do you crave regularly?_____
Do you cook for yourself/your family?_____

Personal History

Height: _____Weight: _____ Do you sleep well?: _____
Where were you born? _____
Was your birth (circle): Normal Premature Long labor Complications
Were you adopted? Yes/No If yes, at what age? _____
Father: If living, age and health: _____
If deceased, age, year, and cause of death: _____
Mother: If living, age and health: _____
If deceased, age, year, and cause of death: _____

Adult Mental Health

Have you received previous counseling? Yes/No Psychiatrist/Psychologist/School Counselor/Clergy
If yes, when, why and was it helpful? _____

_____

_____

Have you been admitted to a psychiatric hospital? Yes/No. If yes, when and where? _____

_____

Have you ever taken psychiatric medications? Yes/No If yes, please list:

Problem	Medication	Dose	Start Date	Stopped Date	Side Effects	Response
1.						
2.						
3.						
4.						

Did you serve in the military? If so, provide details: _____

_____

Spiritual Orientation

Please list your spiritual orientation or religion: _____
How active are these beliefs in your life? __ Very active __Somewhat active __ Not very active

PLEASE LIST ALL PREVIOUS DIAGNOSES AND CIRCLE OR LIST ISSUES WITH THE FOLLOWING:

1. Health in General: ___No Problems. Lack of energy, unexplained weight gain or loss, loss of appetite, fever, night sweats, grinding teeth at night, other: _____

_____

2. Eyes: ___ No Problems. Impaired vision, cataracts, glaucoma, spots in vision, tearing or dryness, eye pain or strain, other: _____

_____

3. Ears, Nose, Mouth and Throat: ___ No Problems. Difficult with hearing, sinus problems, runny nose, ringing in ears, mouth sores, ear pain, nosebleeds, sore throat, facial pain or numbness, other: _____

_____

4. Cardiovascular: ___ No Problems. Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking, other: _____

_____

5. Respiratory: ___ No Problems. Shortness of breath, prolonged cough, wheezing, oxygen at home, coughing up blood, asthma, abnormal chest x-ray, other: _____

_____

6. Genitourinary: ___ No Problems. Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence, other: _____

_____

7. Musculoskeletal: ___ No Problems. Joint pain, aching muscles, swelling of joints, joint deformities, other: _____

_____

8. Gastrointestinal: ___ No Problems. Heartburn, constipation, ulcers, hemorrhoids, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence, other: _____

_____

9. Skin: ___ No Problems. Persistent rash, itching, eczema, acne, hair loss or increase, breast changes, other: _____

_____

10. Neurological: ___ No Problems. Head injuries, frequent headaches, double vision, weakness, problems with walking or balance, dizziness, tremor, loss of consciousness, seizures, episodes of visual loss, other: _____

_____

11. Psychiatric: ___ No Problems. Insomnia, irritability, depression, anxiety, mood swings, hallucinations, compulsions, other: _____

_____

12. Female Reproductive: Age of last menses _____, length of cycle _____, duration of menses ____, : last pap smear _____, number of pregnancies ____, number of live births ____

___ No Problems. Irregular cycle, PMS, abnormal PA smear, birth control, pain during intercourse, difficulty conceiving, breast pain/tenderness, menopausal symptoms, other: _____

_____

_____

_____

13. Male Reproductive: ___ No Problems. Prostate disease, hernias, testicular pain, premature ejaculation, impotence, other: _____

_____

14. Hematological: ___ No Problems. Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas, other: _____

_____

15. Allergies: ___ No Problems. Seasonal allergies, hay fever symptoms, itching, frequent infections, other: _____

_____

Other

Is there anything else you want us to know or that you think would be helpful or important in your health care? _____

_____

_____

_____

_____